NEW EMPLOYEE INFORMATION LIST

NAME _____

ADDRESS _____

DOB _____ SS# _____

RACE _____ GENDER _____

PRIMARY PHONE# _____

EMERGENCY CONTACT & PHONE # _____

_____

PRIMARY EMAIL# _____

ASSIGNED CAMPUS _____

POSITION _____

New Hire Check List

BCBS COVERAGE: _____

NAME: _____ CAMPUS: _____

DOB: _____ HIRE DATE: _____

SALARY: _____ POSITION: _____

1) _____ TEACHING CERTIFICATE

2) _____ VERIFICATION OF EXPERIENCE

_____A, _____AA, _____AAA, _____AAAA EXPIRATION: _____

3) _____ I-9 FORM (SIGNATURE REQUIRED & E-VERIFY CONFIRMATION MUST BE IN FOLDER)

4) _____ W-4 _____ STATE TAX _____BCBS _____WAIVED _____LIFE _____WAIVED

_____ DENTAL _____WAIVED _____VISION _____WAIVED

5) _____ COPY OF DRIVER'S LICENSE & SOCIAL SECURITY CARD

6) _____ DIRECT DEPOSIT (AUTHORIZATION & BLANK CHECK)

7) _____ PERS FORMS (EMAIL TO PERS & PRINT EMAIL)

8) _____ DRUG CONSENT _____ INTERNET AGREEMENT

9) _____ CONTRACT

MEAGAN-

____ CHILD ABUSE REGISTRY CHECK
____ FINGERPRINT & BACKGROUND CHECK
____ DRUG TESTING ($50)
____ E- VERIFY, DRIVER'S LICENSE & SS CARD

____ INS. HIPPA/COBRA/FMLA (MRS. JOY)
____ BOARD APPROVAL
____ REFERENCES (IF APPLICABLE)

SMITH COUNTY SCHOOL DISTRICT

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I (we) authorize Smith County School District to initiate entries to my checking/savings accounts at the financial institutions listed below, and if necessary, initiate adjustments for any transaction credited/debited in error. This authority will remain in effect until Smith County School District is notified by me (us) in writing to cancel it in such time as to afford Smith County School District and the financial institution a reasonable opportunity to act on it.

(NAME OF FINANCIAL INSTITUTION)

(ADDRESS OF FINANCIAL INSTITUTION-BRANCH, CITY, STATE, & ZIP)

CHECKING/SAVINGS (CIRCLE ONE) ACCOUNT NUMBER

FINANCIAL INSTITUTE ROUTING NUMBER

SIGNATURE DATE

NAME- PLEASE PRINT

ADDRESS CITY STATE ZIP CODE

*******PLEASE ATTACH A VOIDED CHECK TO THE BOTTOM OF THIS FORM*******

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Form 89-350-20-8-1-000 (Rev. 08/20)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence

_____ _____ _____ _____
Number and Street | City or Town | State | Zip Code

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION

	Marital Status	Personal Exemption Allowed	Amount Claimed
EMPLOYEE:	1. Single	☐ Enter $6,000 as exemption . . . . ▸	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	2. Marital Status (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▸	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below. ▸	$
	3. Head of Family	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below . . . . . ▸	$
EMPLOYER: **Keep this certificate with your records.** If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	4. Dependents Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed... ▸	$
	5. Age and blindness	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▸ * Note: No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5... ▸		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▸		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "**Exempt**" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▸		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ Date: _____

INSTRUCTIONS

1. **The personal exemptions allowed:**

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. **Claiming personal exemptions:**

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. **Total Exemption Claimed:**
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. **A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.**

5. **PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.**

6. **IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENIFIT OF EXEMPTION.**

To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

Standard 8: Remunerative Conduct

An educator should maintain integrity with students, colleagues, parents, patrons, or businesses when accepting gifts, gratuities, favors, and additional compensation.

8.1. Ethical conduct includes, but is not limited to, the following:
- a. Insuring that institutional privileges are not used for personal gain
- b. Insuring that school policies or procedures are not impacted by gifts or gratuities from any person or organization.

8.2. Unethical conduct includes, but is not limited to, the following:
- a. Soliciting students or parents of students to purchase equipment, supplies, or services from the educator or to participate in activities that financially benefit the educator unless approved by the local governing body
- b. Tutoring students assigned to the educator for remuneration unless approved by the local school board
- c. The educator shall neither accept nor offer gratuities, gifts, or favors that impair professional judgment or to obtain special advantage. (This standard shall not restrict the acceptance of gifts or tokens offered and accepted openly from students, parents, or other persons or organizations in recognition or appreciation of service.)

Standard 9: Maintenance of Confidentiality

An educator shall comply with state and federal laws and local school board policies relating to confidentiality of student and personnel records, standardized test material, and other information covered by confidentiality agreements.

9.1. Ethical conduct includes, but is not limited to, the following:
- a. Keeping in confidence information about students that has been obtained in the course of professional service unless disclosure serves a legitimate purpose or is required by law
- b. Maintaining diligently the security of standardized test supplies and resources.

9.2. Unethical conduct includes, but is not limited to, the following:
- a. Sharing confidential information concerning student academic and disciplinary records, health and medical information family status/income and assessment/testing results unless disclosure is required or permitted by law.
- b. Violating confidentiality agreements related to standardized testing including copying or teaching identified test items, publishing or distributing test items or answers, discussing test items, and violating local school board or state directions for the use of tests
- c. Violating other confidentiality agreements required by state or local policy.

Standard 10: Breach of Contract or Abandonment of Employment

An educator should fulfill all of the terms and obligations detailed in the contract with the local school board or educational agency for the duration of the contract.

10. Unethical conduct includes, but is not limited to, the following:
- a. Abandoning the contract for professional services without prior release from the contract by the school board
- b. Refusing to perform services required by the contract.

This code shall apply to all persons licensed according to the rules established by the Mississippi State Board of Education and protects the health, safety and general welfare of students and educators.

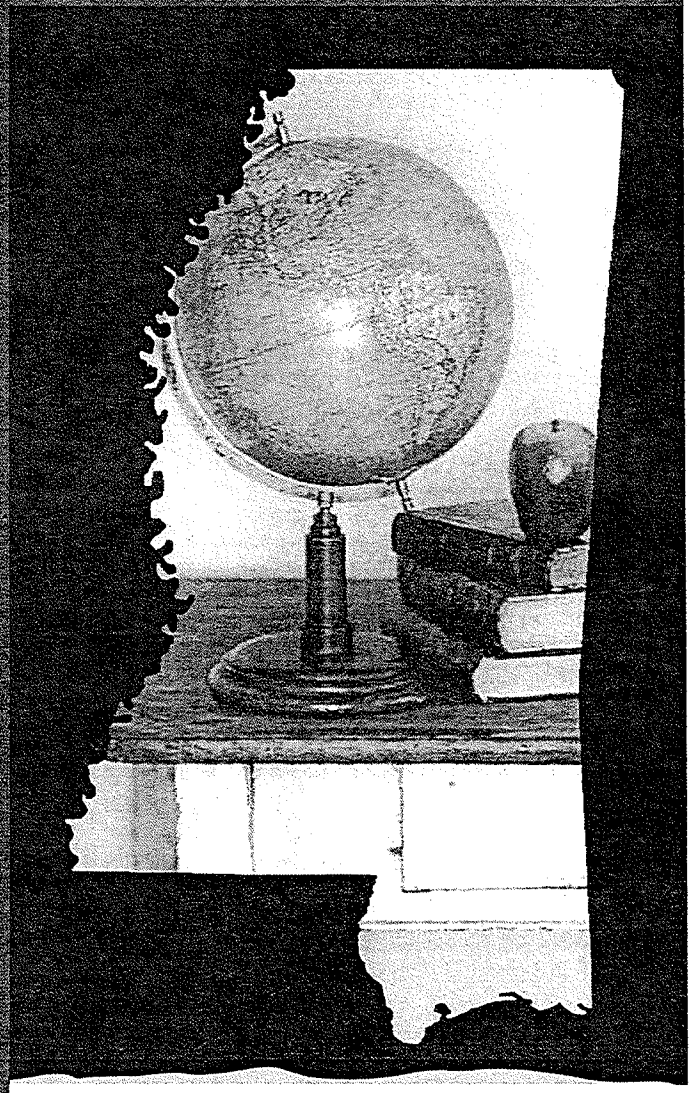
Ethical conduct is any conduct which promotes the health, safety, welfare, discipline and morals of students and colleagues.

Unethical conduct is any conduct that impairs the license holder's ability to function in his/her employment position or a pattern of behavior that is detrimental to the health, safety, welfare, discipline, or morals of students and colleagues.

Any educator or administrator license may be revoked or suspended for engaging in unethical conduct relating to an educator/student relationship (Standard 4). Superintendents shall report to the Mississippi Department of Education license holders who engage in unethical conduct relating to an educator/student relationship (Standard 4).

For more information:
Mississippi Department of Education
359 North West Street
Jackson, MS 39201
601-359-3513
www.mde.k12.ms.us

Mississippi Educator



Code of Ethics

Standards of Conduct

Mississippi Department of Education

SMITH COUNTY SCHOOL DISTRICT

P.O BOX 308
212 SYLVARENA AVE
RALEIGH, MS 39153
601-782-4296
601-782-9895 (FAX)

I, _____, have received, read and understand the

Mississippi Department of Education Code of Ethics Standards of Conduct.

_____ _____

PRINCIPAL DATE

_____ _____

EMPLOYEE DATE

SMITH COUNTY SCHOOL DISTRICT

DRUG AND ALCOHOL TESTING POLICY

The following is Smith County School District's Drug and Alcohol Testing Policy. This policy is effective August 1, 2019. After this date, the district will begin testing personnel if it reasonably suspects that an employee is under the influence of illegal drugs or alcohol. In addition, the district will begin conducting random testing of all bus drivers, and preemployment testing of all prospective employees. This policy will be enforced uniformly with respect to all personnel. All the district's personnel, including administrators, will be subject to testing.

The purposes of this policy are as follows.

1. To maintain a safe, healthy working environment for all employees.
2. To maintain the highest quality educational program for our students by ensuring that no personnel of the district are users of illegal drugs or under the influence of drugs or alcohol.
3. To reduce the number of accidental injuries to person or property; and
4. To reduce absenteeism and tardiness and improve the quality of educational services.

SUBSTANCE ABUSE

The following are rules representing the district's policy concerning substance abuse.

1. All employees are prohibited from being under the influence of drugs or alcohol while on duty or on district premises. All employees are prohibited from using illegal drugs, or prescription medication for which they do not have a proper prescription.

2. The use, sale, possession, transfer, or purchase of illegal drugs, non-prescription drugs, medical marijuana, or controlled substances while on district property or while performing district business is strictly prohibited and is cause for immediate termination. Such action will be reported to appropriate law enforcement officials.

3. No alcoholic beverage will be brought or consumed on district premises.

4. No prescription drug will be brought on district premises by any person other than the person for whom the drug is prescribed. Prescription drugs will be used only in the manner, combination, and quantity prescribed.
5. The district is not prohibited from establishing or enforcing a drug-testing policy under the Mississippi Medical Cannabis Act. The district is not required to permit, accommodate, or allow the use of medical cannabis, or to modify any job/working conditions of any employee who engages in the medical use of medical cannabis or who for any reason seeks to engage in the medical use of medical cannabis.

6. The district is not prohibited from taking an adverse employment action against an employee, up to and including termination, as a result, in whole or in part, of that individual's use of medical cannabis, regardless of the individual's impairment or lack of impairment resulting from the medical use of cannabis.
7. Any employee whose off-duty use of alcohol, medical marijuana, illegal, or non-prescription drugs results in excessive absenteeism, tardiness, poor work, or an accident will be subject to discipline, up to and including termination.

DRUG AND ALCOHOL TESTING

1. Effective August 1, 2019, the Smith County School District will begin conducting preemployment testing, reasonable suspicion testing of all personnel and random testing of bus drivers.

2. An employee will be allowed to provide notice to the Smith County School District of currently or recently used prescription or non-prescription drugs prior to the time of the test.

3. Random testing of bus drivers will be implemented using a neutral selection basis. Smith County School District will not waive the selection of any employee chosen pursuant to the random selection procedures.

4.

    a. Reasonable suspicion is defined under this policy as the belief by Smith County School District that an employee is using or has used drugs or alcohol in violation of Smith County School District's policy. Reasonable suspicion may be based upon, among other things:

        i. Observable phenomena, such as direct observation of drug use and/or the physical symptoms or manifestations of being under the influence of a drug;

        ii. Abnormal conduct or erratic behavior while at work, absenteeism, tardiness, or deterioration in work performance;

        iii. A report of drug use provided by reliable and credible sources, and which has been independently corroborated;

        iv. Evidence that an individual has tampered with a drug and alcohol test during his employment with the current employer;

v. Information that an employee has caused or contributed to an accident while at work; and

vi. Evidence that an employee is involved in the use, possession, sale, solicitation, or transfer of drugs while working or while on school premises or while operating one of the school's vehicles, its machinery, or its equipment.

b. If there is reasonable suspicion that an employee is using or has used drugs or consumed alcohol in violation of Smith County School District's policy, that employee will be required to submit to a drug and/or alcohol test. The superintendent (or in his or her absence an appointed replacement) must approve in advance all reasonable suspicion testing. If the test result is confirmed positive for drugs or alcohol in violation of Smith County School District's drug and alcohol policy, the employee will be subject to immediate termination of his or her employment with the district.

5. Any employee who refuses to take a drug and alcohol test will be subject to discipline, up to and including immediate termination of employment.

6. The following are drugs for which the district may test: alcohol, opiates, amphetamines, phencyclidine (PCP), marijuana, cocaine, and any other illegal drugs.

7. An employee who receives a positive confirmation drug and alcohol test result may contest the accuracy of the result or explain the results within ten days of the date of such result by filing a written statement with the superintendent. An employee, at his or her own cost, also may request that the specimen be retested at a certified laboratory of his or her own choosing.

8. An employee who receives a positive confirmation test result and who fails to present a satisfactory contest or explanation to such result, or a contrary result from a certified laboratory of the employee's own choosing, will be subject to discipline, up to and including termination.

9. If the district determines that discipline and/or discharge are not necessary or appropriate in a case where an employee is in violation of Smith County School District's Drug and Alcohol Testing Policy, the employee as a condition of continued employment must complete a certified substance abuse rehabilitation program at the employee's own cost and expense. The employee may be allowed to work for the district while undergoing the treatment, but the employee must provide evidence of continued treatment and/or rehabilitation upon request. The employee must also agree to submit to random testing for three years after the date of the positive confirmation drug and alcohol test result.

A copy of this policy, and state law regarding drug testing can be obtained from the district office.

SMITH COUNTY SCHOOL DISTRICT

DRUG CONSENT AND RECEIPT OF INFORMATION FORM

I understand that it is the Smith County School District's policy to prohibit the use, possession, transportation, or sale of illegal or non-prescription drugs, and alcoholic beverages on the premises of the district. I understand that it is a violation of the district's policy to be under the influence of drugs and alcohol while on its premises. My signature below constitutes my consent to provide a sample of my blood, breath, urine or other related sample for alcohol and drug testing analysis administered in accordance with Mississippi Code Annotated Sections 71-7-1 et seq. Supp. (1994). I understand the failure to cooperate with any testing procedure may result in discipline up to and including discharge. I confirm that I have reviewed, or been given the opportunity to review Smith County School District's Drug and Alcohol Testing Policy.

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____

DATE: _____

Technology & User Agreement Handbook

Smith County School District (SCSD) provides the privilege of Internet access to district faculty, staff, students, and occasionally guests. Each user, as well as a minor's parent or guardian, voluntarily agrees to release, hold harmless, defend, and indemnify, the Smith County School District, its officers, board members, employees, and agents, for and against all claims, actions, charges, losses or damages which arise out of the user's use of the SCSD network, but not limited to negligence, personal injury, wrongful death, property loss or damage, delays, non-deliveries, miss-deliveries of data, or service interruptions. SCSD will fully cooperate with local, state or federal officials in any investigation related to illegal activities conducted through the user's Internet account.

Access can & will be restricted as required to comply with the Children's Internet Protection Act (CIPA). Web browsing may be monitored, and records are retained to ensure compliance.

Users are expected to respect the SCSD web filter and shall not attempt to circumvent the filter when browsing the Internet while using the SCSD network, either wired or wirelessly. The determination of whether material is appropriate or inappropriate is based solely on the content of the material and the intended use of the material, not on whether a website has been blocked or not. If a user believes a site is unnecessarily blocked, the user should submit a technology work order to review the site and have the head principal of the campus send to the Director of Technology for review.

Each user acknowledges that the information available from other websites may not be accurate. Use of any of the information obtained via the Internet is at the user's own risk.

Smith County School District makes no warranty of any kind, either expressed or implied, regarding the quality, accuracy or validity of the data on the Internet.

SCSD NETWORK RULES

A. *The person to whom an SCSD network account is issued is responsible at all times for its proper use.*
B. *Any inappropriate use may result in the cancellation of the privilege of use, and/or disciplinary action. Consequences for any user who fails to comply with SCSD and school guidelines may include paying for damages, denial of access to technology, detention, suspension, expulsion or other remedies applicable under the school disciplinary policy, and state or federal law.*
C. *Any district employee who uses the SCSD network inappropriately is subject to disciplinary action, including dismissal.*
D. *Under no conditions should a SCSD network user give their password information to another user nor allow another user to utilize their account unless speaking directly to a technology department employee who is assisting them.*
E. *Schools may supplement any provisions of the District AUP (Acceptable Use Policy), and may require additional parent releases and approvals, but in no case will such documents replace the District AUP.*
F. *Users will immediately report to school district authorities any attempt by other network users to engage in inappropriate conversations or personal contact.*
G. *Any non-standard software that is needed to perform a specific job function will need to be brought to the attention of the Technology Director. Those applications shall be the sole responsibility of that department and if the application interferes with any required programs, applications, and utilities, it should not be used and if in use, it may be disabled.*

ACCEPTABLE USES OF TECHNOLOGY

(Not all Inclusive)

This is not intended to be an exhaustive list. Users should use their own good judgment when using SCSD technology.

H. *Use school technologies for school-related activities.*
I. *Follow the same guidelines for respectful, responsible behavior online that they are expected to follow offline.*
J. *Treat school resources carefully and alert administrative staff if there is any problem with the technical operations of a device.*
K. *Encourage positive, constructive discussion if allowed to use communicative or collaborative technologies.*
L. *Alert a teacher, administrator, or other staff member if they see threatening, inappropriate, or harmful content (images, messages, and posts) online.*
M. *Use District technologies at appropriate times, in approved places, for educational pursuits.*

UNACCEPTABLE USES OF THE TECHNOLOGY

(Not all *Inclusive)*

N. Violating any state and/or federal law (i.e., copyright laws).

O. Using profanity, obscenity, or other language that may be offensive to others.

P. Making personal attacks on other people, organizations, religions, or ethnicities.

Q. Accessing, downloading, storing, or printing files or messages that are sexually explicit, obscene, or that offend or tend to degrade others. (The administration invokes its discretionary rights to determine such suitability.)

R. Not respecting the privacy of a person by posting personal contact information, such as work/home address, telephone, email, photographs, or names, without obtaining prior permission from the person affected. Student information shall be posted only with written parent/guardian permission.

S. Forwarding personal communication without the author's prior consent. Using the Internet for commercial purposes, financial gain, personal business, producing advertisement, business service endorsement, or religious or political lobbying is prohibited.

T. Destroying or altering the files of another user or viewing or taking the files of another user.

USE OF OUTSIDE EMAIL PROVIDERS & STIPULATIONS FOR USING DISTRICT EMAIL CLIENT AS DISTRICT REPRESENTATIVE

(Teachers, Administrators, Managers, etc.)

Use of "Internet mail" by students, staff, and faculty such as Yahoo mail, Gmail, and POP3 accounts provided by their "home" Internet service providers is NOT permitted. Beginning in the 2019-2020 school year, the District blocks the use of Internet mail accounts not managed by SCSD. All "OFFICIAL" communications, e.g., Teacher to Parent, Teacher to Student, Staff to Staff, must be via the district's e-mail system or at any given time an approved solution for such communications. This includes, but is not limited to, teachers who guide extracurricular activities such as Clubs, Choirs, Bands, Athletics, and the like.

FILTERING

An Internet filter is in place for Smith County School District. This filter is a critical component of the SCSD network as well as the federally required Children's Internet Protection Act (CIPA)

compliance ruling since it allows valuable online Internet access while restricting access to specific unwanted material in the following categories:

Pornography, Gambling, Illegal Drugs, Online Merchandising, Hate Speech, Criminal Skills, Alternative Journals and Other Undesirable Materials.

The filter is updated daily to restrict access to the above items. Filtering is not a 100% foolproof way of limiting access to appropriate sites. Inappropriate sites are added to the Internet daily. Students will be supervised at all times by a teacher while using the Internet. All Internet hits are logged and archived to include the date/time, IP address and account of the user of the workstation making the request.

Attempts to bypass the school Internet filters is in violation of this acceptable use policy and will be subject to disciplinary action that may include denial of access to technology, detention, suspension, expulsion, termination of employment or other remedies applicable under the school disciplinary policy, and state or federal law.

WORKSTATION MONITORING

All data transferred and/or transmitted over the SCSD network is monitored and recorded. All data transferred or transmitted over the network can be tracked and identified, and the originating user can be held liable if their use of the network/device violates any established policy, regulation, or law. Any data stored on district owned equipment may be archived and preserved by the district for an indefinite period.

Such data includes, but is not limited to email, text documents, digital photographs, music, and other digital or electronic files. If a device continues to try to connect to an inappropriate site, that device will be remotely monitored and the individual using that workstation will be reported to District Administration.

TECHNOLOGIES COVERED

SCSD may provide the privilege of Internet access, desktop computers, mobile computers or devices, video conferencing capabilities, online collaboration capabilities, email, and more.

The Acceptable Use Policy applies to both District-owned technology equipment utilizing the SCSD network, the SCSD Internet connection, and/or private networks/Internet connections accessed from District-owned devices at any time.

Thus, the AUP also applies to privately owned devices accessing the SCSD network, the SCSD Internet connection, and/or private networks/Internet connections while on school property or participating in school functions or events off campus. SCSD policies outlined in this document cover all available technologies now and in those released in the future, not just those specifically listed or currently available.

EMAIL

Employees and students SCSD email is the property of SCSD. SCSD archives all employee & student email. It is the responsibility of the employee and student to maintain this email account appropriately. When user email accounts are suspended due to the end user no longer being enrolled or employed by SCSD, the account will not be restored without the user making a person meeting with members of the IT Staff.

SECURITY

Users are expected to take reasonable safeguards against the transmission of security threats over the SCSD network. This includes not opening or distributing infected files or programs and not opening files or programs of unknown or untrusted origin. Users should never share personal information about other employees or any student using email.

If users believe a computer or laptop they are using might be infected with a virus, they should alert the Technology Department. Users should not attempt to remove the virus themselves or download any programs to help remove the virus.

ONLINE ETIQUETTE

Users should always use the Internet, network resources, and online sites in a courteous and respectful manner. Users should recognize that among the valuable content online there is also unverified, incorrect, or inappropriate content. Users should only use known or trusted sources when conducting research via the Internet.

Users should remember not to post anything online that they would not want students, parents, teachers, or future colleges or employers to see. Once something is online, it cannot be completely retracted and can sometimes be shared and spread in ways the user never intended.

PLAGIARISM

Users should not plagiarize (or use as their own, without citing the original creator) content, including words or images, from the Internet. Users should not take credit for things they did not create themselves, or misrepresent themselves as an author or creator of something found online. Information obtained via the Internet should be appropriately cited, giving credit to the original author.

PERSONAL SAFETY

Users should never share personal information, including phone number, address, a Social Security Number, birthday, or financial information, over the Internet without a signed compliance form from a parent or guardian of any student. Users should recognize that communicating over the Internet brings anonymity, associated risks, and should carefully

safeguard the personal information of themselves and others. Users should never agree to meet in person someone they meet online without parental / guardian permission.

If users see a message, comment, image, or anything else online that makes them concerned for their personal safety or the safety of someone else, they should immediately bring it to the attention of an adult (teacher or administrator if at school, parent if using the device at home).

CYBER BULLYING

Cyber bullying includes, but is not limited to, harassing, flaming, denigrating, impersonating, outing, tricking, excluding, and cyber stalking, as such cyber bullying will not be tolerated. Users should not send emails or post comments with the intent to harass, ridicule, humiliate, intimidate, or harm the targeted individual and create for the targeted individual a hostile school environment.

Engaging in these behaviors or in any online activities intended to harm (physically or emotionally) another person, will result in disciplinary action described in SCSD Policy IJNDB-1 – Responsible Use of the Internet and Cyber Bullying. In some cases, cyber bullying can be a crime. Users should remember that online activities might be monitored.

All students will be educated about appropriate online behavior, including interacting with other persons on social networking websites and in chat rooms, and cyber bullying awareness and response.

LIMITATION OF LIABILITY

SCSD will not be responsible for damage or harm to persons, files, data, or hardware. While SCSD uses filtering and other safety and security mechanisms, and attempts to ensure their proper function, it makes no guarantees as to their effectiveness.

SCSD will not be responsible or liable for, financially or otherwise, unauthorized transactions conducted over the SCSD network.

VIRTUAL MEETINGS

All virtual meetings hosted by any SCSD employee are monitored and recorded. Virtual meetings are an extension of the school the student attends and follows any rules or guidelines set by that school. The teacher reserves the right to limit the student's ability to communicate or attend any school sanctioned virtual meeting.

SMITH COUNTY SCHOOL DISTRICT

EMPLOYEE INTERNET AGREEMENT

As an employee of the Smith County School District and as a user of the district computer network, I have read and hereby agree to comply with the Smith County School District Acceptable Use Policy.

I understand any violations of the above provisions may result in the loss of my user account and disciplinary and/or legal action, including but not limited to loss of my employment. I understand my responsibility to report any misuse of the electronic information resources to my site administrator/supervisor or systems administrator.

I have read this agreement and understand that Internet sites are filtered and that my district computer use is being monitored.

SIGNATURE:_____ DATE: _____

FULL NAME (please print):_____

CAMPUS: _____

POSITION: _____

THIS SIGNED SHEET IS TO BE KEPT IN THE EMPLOYEE'S PERSONNEL FILE.

PERS of MISSISSIPPI

Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member Information – *Attach a copy of the member's Social Security card.*

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? *If yes, attach Form(s) DD214* ..... ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ..... ☐ Yes ☐ No

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Family Information – *Use additional* Membership Applications *if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

Marital Status – *Select one. Add date for last three.* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date *mm/dd/ccyy*: _____

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Member's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member.*

Member's Position Held/Job Title: _____ **Member's Hire Date** *mm/dd/ccyy*: _____

Member's Status: Elected Official: ☐ Yes ☐ No Fee Paid Official: ☐ Yes ☐ No Public Safety Employee: ☐ Yes ☐ No

Employer Name: SMITH COUNTY BOARD OF EDUCATION Employer No.: 0515 - 000

Employer Representative's Name: HEATHER CORLEY Employer Representative's Title: PAYROLL OFFICER

Employer Representative's Phone: (601) 782-4296 Fax: (601) 782-9895 E-Mail: heather.corley@smithcountyschools.net

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

PERS of MISSISSIPPI

Beneficiary Designation

Form 1B – Revised 08/30/2022

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Retiree

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ Gender: ☐ M ☐ F

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary beneficiaries must equal 100 percent, and total secondary beneficiaries must equal 100 percent. Secondary beneficiaries will only receive payment if all listed primary beneficiaries are deceased.*

Beneficiary Name	Social Security No.	Birth Date *mm/dd/ccyy*	Relationship	Beneficiary Percentage *P=Primary, S=Secondary Use whole numbers*	Gender
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F
				☐P ☐S _____ %	☐M ☐F

❹ Member/Retiree Certification – *Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

☐ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree –** I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member. Only complete for active members.*

Employer Name: SMITH COUNTY BOARD OF EDUCATION Employer No.: 0515 - 000

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: (601) 782-4296 Fax: (601) 782-9895 E-Mail: heather.corley@smithcountyschools.net

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

DELTA DENTAL

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
Fax: 770-641-5393

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

SELECT PLAN: LOW PLAN _____

HIGH PLAN _____

For Employer Use Only	
Effective Date / /	Group No.:
Full Time Hire Date / /	Sublocation:

Check One (**Enrollees can change plans only during open enrollment.)

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Change Dental Plans**
- ❑ COBRA
- ❑ Add/Delete Dependent
- ❑ Terminate Employee Coverage
- ❑ Spouse Employment Change
- ❑ Marital Change
- ❑ Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce
- ❑ Widowed/Surviving Dependent
- ❑ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single ❑ Married ❑ Gender: Male ❑ Female ❑ Phone # ( ) —

Do you have dependent children? Yes ❑ No ❑ Are you or your dependents covered under another dental plan? Yes ❑ No ❑

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

❑ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____

Plans and Rates

Smith County School District

Delta Dental PPO			Program E Plan I – High
	Delta Dental PPO Dentist	**Delta Dental Premier Dentist**	**Non-Delta Dental Dentist**
Maximum Contract Allowance	PPO Contracted Fees	Premier Contracted Fees	90th Percentile
Benefits			
Diagnostic & Preventive	100%	100%	100%
Sealants	100%	100%	100%
Space Maintainers	100%	100%	100%
Basic Restorative	80%	80%	80%
Oral Surgery	50%	50%	50%
Simple Extractions	80%	80%	80%
Endodontics	50%	50%	50%
Surgical Periodontics	50%	50%	50%
Non-Surgical Periodontics	50%	50%	50%
Major Restorative	50%	50%	50%
Prosthodontics-Fixed & removable	50%	50%	50%
Denture Repair and Relining	50%	50%	50%
Implants	Not Covered	Not Covered	Not Covered
Orthodontics – Child	50%	50%	50%
Orthodontics – Adult	Not Covered	Not Covered	Not Covered
TMJ	Not Covered	Not Covered	Not Covered
Deductible (Does not apply to Diagnostic and Preventive Services)			
Per Patient / Calendar year	$50	$50	$50
Per Family / Calendar year	$150	$150	$150
Maximums			
Per Patient / Calendar year	$1500	$1500	$1500
Lifetime Ortho maximum/ Patient	$1000	$1000	$1000
Waiting Periods (Calculated from each primary enrollee's effective date in a dental program as reported by the employer)			
Oral Surgery, Endo, Perio	NA	NA	NA
Orthodontics	12 months	12 months	12 months
Major Restorative, Prosthodontics	6 months	6 months	6 months

Assumptions and Guidelines

Smith County School District — Program E Plan I - High

The rates quoted in this proposal are based on the information provided to Delta Dental at the time the proposal was released. This proposal is not a contract. If the group wishes to sign a contract with Delta Dental, it will be required to complete and sign a Group Application. Delta Dental's acceptance of a completed Group Application will be based on verification of group enrollment specifications.

If during the Contract Term any new or increased tax, assessment or fee is imposed on the amounts payable to or by Delta Dental under this Contract or any immediately preceding contract between Delta Dental and Contractholder, the Premium amount will be increased by the amount of any such new or increased tax, assessment or fee by written notice to Contractholder, and the Contract shall thereby be modified on the date set forth in the notice.

Maximum Contract Allowance

Contracted dentists are paid directly by Delta Dental and by agreement cannot bill the enrollee more than their contracted fee. Non-contracted dentists may not always accept Delta Dental's program allowance as payment in full. The enrollee is responsible for paying up to the non-contracted dentist's submitted charge.

Fully Insured Non-Retention Contract

Any profit or loss remaining at the end of the contract period will be absorbed by Delta Dental. The client assumes no liability in a loss situation.

Rate Guarantee

Rates are valid if purchased by the proposed effective date of 1/1/19. Delta Dental recommends 90 days advance notice for implementation.

Contribution and Participation

Rates assume an employer contribution of 0% toward the employee cost and 0% toward the dependent cost of coverage for all eligible employees. Rates assume that there will be a minimum enrollment of 161 primary enrollees.

Eligibility

Eligible employees may enroll on the first day of the month following completion of the employer's required eligibility period. Eligible employees who decline dental coverage may elect to enroll at the next open enrollment. The same requirements also apply for dependent coverage. Primary enrollees electing dependent coverage must enroll all eligible dependents in the dental program. Eligibility for employees and dependents is subject to all state laws or regulatory requirements. Enrollees eligible for optional continuation of group benefits under the Consolidated Omnibus Reconciliation Act of 1986 (COBRA) may continue coverage as allowed by law.

Limitations and Exclusions

The proposed plan will be administered under Delta Dental's benefits, limitations and exclusions.

Plans and Rates

Smith County School District

Delta Dental PPO			Program E Plan II - Low
	Delta Dental PPO Dentist	**Delta Dental Premier Dentist**	**Non-Delta Dental Dentist**
Maximum Contract Allowance	PPO Contracted Fees	Premier Contracted Fees	90th Percentile
Benefits			
Diagnostic & Preventive	100%	100%	100%
Sealants	100%	100%	100%
Space Maintainers	100%	100%	100%
Basic Restorative	80%	80%	80%
Oral Surgery	Not Covered	Not Covered	Not Covered
Simple Extractions	80%	80%	80%
Endodontics	Not Covered	Not Covered	Not Covered
Surgical Periodontics	Not Covered	Not Covered	Not Covered
Non-Surgical Periodontics	80%	80%	80%
Major Restorative	Not Covered	Not Covered	Not Covered
Prosthodontics-Fixed & removable	Not Covered	Not Covered	Not Covered
Denture Repair and Relining	Not Covered	Not Covered	Not Covered
Implants	Not Covered	Not Covered	Not Covered
Orthodontics – Child	Not Covered	Not Covered	Not Covered
Orthodontics – Adult	Not Covered	Not Covered	Not Covered
TMJ	Not Covered	Not Covered	Not Covered
Deductible (Does not apply to Diagnostic and Preventive Services)			
Per Patient / Calendar year	$50	$50	$50
Per Family / Calendar year	$150	$150	$150
Maximums			
Per Patient / Calendar year	$1500	$1500	$1500
Lifetime Ortho maximum/ Patient	Not Covered	Not Covered	Not Covered
Waiting Periods (Calculated from each primary enrollee's effective date in a dental program as reported by the employer)			
Oral Surgery, Endo, Perio	NA	NA	NA
Orthodontics	NA	NA	NA
Major Restorative, Prosthodontics	NA	NA	NA

Assumptions and Guidelines

Smith County School District **Program E Plan II - Low**

The rates quoted in this proposal are based on the information provided to Delta Dental at the time the proposal was released. This proposal is not a contract. If the group wishes to sign a contract with Delta Dental, it will be required to complete and sign a Group Application. Delta Dental's acceptance of a completed Group Application will be based on verification of group enrollment specifications.

If during the Contract Term any new or increased tax, assessment or fee is imposed on the amounts payable to or by Delta Dental under this Contract or any immediately preceding contract between Delta Dental and Contractholder, the Premium amount will be increased by the amount of any such new or increased tax, assessment or fee by written notice to Contractholder, and the Contract shall thereby be modified on the date set forth in the notice.

Maximum Contract Allowance
Contracted dentists are paid directly by Delta Dental and by agreement cannot bill the enrollee more than their contracted fee. Non-contracted dentists may not always accept Delta Dental's program allowance as payment in full. The enrollee is responsible for paying up to the non-contracted dentist's submitted charge.

Benefit payments for services rendered by non-contracted dentists are sent directly to the enrollee. It is the enrollee's responsibility to pay the non-contracted dentist.

Fully Insured Non-Retention Contract
Any profit or loss remaining at the end of the contract period will be absorbed by Delta Dental. The client assumes no liability in a loss situation.

Rate Guarantee
Rates are valid if purchased by the proposed effective date of 1/1/19. Delta Dental recommends 90 days advance notice for implementation.

Contribution and Participation
Rates assume an employer contribution of 0% toward the employee cost and 0% toward the dependent cost of coverage for all eligible employees. Rates assume that there will be a minimum enrollment of 161 primary enrollees.

Eligibility
Eligible employees may enroll on the first day of the month following completion of the employer's required eligibility period. Eligible employees who decline dental coverage may elect to enroll at the next open enrollment. The same requirements also apply for dependent coverage. Primary enrollees electing dependent coverage must enroll all eligible dependents in the dental program. Eligibility for employees and dependents is subject to all state laws or regulatory requirements. Enrollees eligible for optional continuation of group benefits under the Consolidated Omnibus Reconciliation Act of 1986 (COBRA) may continue coverage as allowed by law.

VSP℠
Vision care for life

Enrollment Form with Dependent Data

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Type of coverage selected:
- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and children
- ☐ employee and family
- ☐ waive coverage

*** Dependent Relationship:** S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

VSP Choice Plan® Proposal

Prepared for Smith County SD

The VSP Choice Plan is a full-service plan that offers low costs, a focus on health, and real provider choices.

Guaranteed Lowest Out-of-Pocket Costs

Our Member Promise guarantees that employees are completely satisfied with their eye care and eyewear from VSP network providers, or we'll make it right. This includes satisfaction with out-of-pocket costs, consumer's #1 priority in a vision plan. We guarantee your employees will have the lowest out-of-pocket costs for equivalent glasses with VSP network providers, compared to your current vision plan, if applicable. One of the ways we reduce patient out-of-pocket costs is by applying fixed copays toward popular lens enhancements. Progressive lenses are a great example with a flat copay of $55 for any standard progressive, and our standard formulary is more than twice the size of some other vision competitors. Unlike most competing vision plans, we also offer a wholesale frame pricing guarantee allowing us to cover more frames.

A Focus on Health - VSP's Eye Health Management Program®

For every dollar our clients spend on a VSP eye exam, they can expect on average, a four-year total return on investment of $1.45 in avoided medical costs and **improved employee productivity** according to a recent independent study by Human Capital Management Services. And VSP network providers detected signs of certain chronic conditions before any other healthcare provider. We've also seen a 22% increase in members with diabetes getting an annual exam thanks to our exam reminders.

Real Provider Choices

Your employees can choose their provider from **81,000 access points**, including the largest national network of independent doctors and nearly 15,000 participating retail chain access points.

VSP Doctors - 91% offer early morning, evening and weekend appointments. 24-hour access to emergency care.

Participating Retail Chains[1] - Your employees get the convenience of popular retail chains like these and more.

Direct Pay Convenience - It's simple for your employees to use their VSP out-of-network benefits at Walmart® and Sam's Club®. Employees say, "I have VSP," and we do the rest. Hundreds of frames are available at no extra cost.

VSP Benefits subject to applicable copays[2]

Exam Services	Comprehensive WellVision Exam® covered-in-full after copay Contact lens exam - fitting and evaluation (when choosing contacts): **Standard** and **Premium fit**: Covered in full with a copay. Member receives 15% off[3] of contact lens exam services;[4] member's copay will never exceed $60 Routine retinal screening covered after an up to $39 copay[3]		
Lenses	Glass or plastic:	Single vision Lined bifocal Lined trifocal Lenticular	Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay
Frame	• Frames covered-in-full after copay up to the retail allowance of $130[5] • Frame allowance is guaranteed by a $50 wholesale allowance at VSP doctors, ensuring nearly 12,000 frames are covered-in-full • Members who select a featured frame brand including bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more will receive an extra $20 toward their frame allowance.[6] • 20% off[3] any amount above the retail frame allowance[4] • Members can choose from virtually any frame on the market		

Our proposal is based on the scope of the obligations that VSP agrees to undertake. VSP will comply with state and/or federal rules and regulations as they pertain to pre-paid vision plans with a defined benefit

VSP CHOICE PLAN®
COMMERCIAL BUSINESS RATES

Voluntary Participation 0-24% Employer Paid
51+ Enrolled Employees
For Clients Headquartered in Mississippi
Valid Until January 1, 2019

VSP Vision Care

Prepared for Smith County SD

Plan Guidelines

- Individual Experience is not available for Pooled Groups
- 21 month rate guarantee and contract term
- These voluntary pooled rates are based on enrollment of 51+ employees
- Platform participation and associated fees are not included
- The first copay applies to the eye examination and the second copay applies to materials
- Rates include all applicable taxes and health assessment fees known as of the date of the proposal

Plan Frequencies

	PLAN B
Eye Exam	12 Months
Lens	12 Months
Frame	24 Months

The base rates quoted reflect VSP's standard in-network retail allowances of $130 for frames and $130 for elective contact lenses.

MONTHLY RATES

4 Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: $10/$25	**$7.79**	**$12.47**	**$12.73**	**$20.52**
Total:	**$7.79**	**$12.47**	**$12.73**	**$20.52**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		PAYROLL OFFICER

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
CORLEY	HEATHER	SMITH COUNTY SCHOOL DISTRICT

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
212 SYLVARENA AVE. SUITE C/ PO BOX 308	RALEIGH	MS	39153

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

securian FINANCIAL™

Mississippi State & School Employees' Life Insurance Plan

Group term life and accidental death & dismemberment (AD&D) benefit

Active full-time employees

Insurance products issued by:
Minnesota Life Insurance Company

Designate your beneficiary today!

We strongly encourage you to designate your beneficiary as soon as possible, even if you believe the selected individual may receive the benefit by default. Designating a beneficiary speeds payment and ensures the proceeds from your policy will be distributed according to your wishes.

To designate your beneficiary online:

1. Log into Blue Cross & Blue Shield of Mississippi: **bcbsms.com**
2. Click on the "My Benefits" tab
3. Click on the "Life Benefits" section
4. Click on the link "Click here to update your beneficiary information"
5. Click "I agree" to go to Securian Financial's LifeBenefits to add, view or update your beneficiary
6. Click "View details or make changes"
7. Enter the name(s), address and the respective benefit percentages for each beneficiary
8. Securian will mail you a confirmation letter after you complete your designation

Need assistance?

Instructions and/or forms for designating a beneficiary may be found on Securian Financial's website: **lifebenefits.com/plandesign/mississippi** or call **877-348-9217**.

Your basic coverage

Basic coverage (automatically enrolled)	
✓ **Basic term life and AD&D** **2x** base annual pay	• Maximum coverage: **$100,000** • Includes matching AD&D benefit

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to Mississippi State and School Employees' Life Insurance Plan. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the "actively at work" requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products offered under policy form series MHC-96-13180.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its affiliates.

Securian Financial Group, Inc.
securian.com

400 Robert Street North, St. Paul, MN 55101-2098

F77223-66 Rev 6-2018 DOFU 6-2018
517949

STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone: Alternate Phone:
Employer Name: SMITH COUNTY SCHOOL DISTRICT				Employer Phone: (601) 782-4296
Employer Address: PO BOX 308, RALEIGH, MS 39153				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of $30,000 and a maximum of $100,000. The employee and employer each pay 50 percent of the monthly premium.

☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

☐ **Late Enrollee Applicant** – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (**Employee must also complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY* form.**)

Date of Employment: _____

☐ **RETIRED EMPLOYEE:** Life benefit amounts are limited to $5,000, $10,000 or $20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ **COVERAGE AMOUNT REQUESTED:** ☐ **$5,000** ☐ **$10,000** ☐ **$20,000**

☐ **DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.

(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *my*Blue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone

SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee/Retiree Signature (Required) **Date**

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

Employee/Retiree Signature **Date**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT http://KnowYourBenefits.dfa.ms.gov/ OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

Beneficiary Designation

Securian Financial Group, Inc.
Minnesota Life Insurance Company
Securian Life Insurance Company, a New York authorized insurer
400 Robert Street North • St. Paul, Minnesota 55101-2098

Group Customer Service
Fax 651-665-4827

SECURIAN®

Visit https://bcbsms.com to designate your beneficiary.

EMPLOYER NAME: Mississippi State and Schools Employees' Life Insurance Plan **POLICY NUMBER: 33683**

Insured's name (last, first, middle initial)	Last four digits of SSN
Address (street, city, state, zip)	

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address

This beneficiary designation applies to all eligible coverages.

INSTRUCTIONS:

1. Clearly print or type the information below.
2. **Sign and date the completed form.**
3. Return to Securian at address above.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature	Date
X	

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Doe - Trustee, his successors or successor in trust under the John Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008.			N/A	Trust	100%

Total = 100%

Know Your Benefits

MISSISSIPPI'S STATE & SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN

Plan Document Notice

The State and School Employees' Life and Health Insurance Plan Document is available online. You can access this valuable resource by visiting the Plan's website at dfa.ms.gov/insurance.

A paper copy may be requested by completing the bottom section of this form and returning it to:

Department of Finance and Administration
c / o Office of Insurance
P.O. Box 24208
Jackson, MS 39225-4208

PLEASE PRINT LEGIBLY

2023 Plan Document Request

Name: _____

Address: _____

City, State, ZIP Code: _____

Know Your Benefits

MISSISSIPPI'S STATE & SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN

Plan Document Notice

The *State and School Employees' Life and Health Insurance Plan Document* contains the benefits and eligibility guidelines of the State and School Employees' Life and Health Insurance Plan (Plan). You can find the latest Plan Document on our website, dfa.ms.gov/insurance under *Publications*. Also on the site are links to find a participating provider, information on covered wellness and preventive services, and the latest premium rates.

You may request a paper copy of the Plan Document by calling the Department of Finance and Administration (DFA) Office of Insurance toll free at (866) 586-2781 or (601) 359-3411 or by sending an email to KnowYourBenefits@dfa.ms.gov.

- The DFA Office of Insurance provides day-to-day management of the Plan for the State and School Employees' Health Insurance Management Board.
- Blue Cross & Blue Shield of Mississippi (BCBSMS) is the Plan's medical claims administrator. BCBSMS processes health claims and maintains eligibility information.
- Keystone Peer Review Organization, Inc. (Kepro) is the Plan's medical case management administrator. Kepro provides medical case management and pre-certification services.
- CVS Caremark is the Plan's pharmacy benefit manager and is responsible for processing prescription drug claims and managing the Plan's prescription drug mail order program.
- The AHS State Network is a system of physicians, hospitals and other health care providers who have agreed to accept the allowable charges set by the Network and file claims for medical services provided to Plan participants. Participant will receive the maximum benefit by using a "participating" network provider.

For questions about medical claims, call **Blue Cross & Blue Shield of Mississippi** (800) 709-7881	To certify a hospital admission or other service, call **Kepro** (888) 801-1910	For questions about prescription drug claims, call **CVS Caremark** (888) 996-0050	To find a participating provider, call **AHS State Network** (800) 294-6307	For general questions about the Plan, call the **DFA Office of Insurance** (866) 586-2781

motivating MISSISSIPPI

keys to living healthy

MISSISSIPPI'S STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN APPLICATION FOR COVERAGE

PLEASE PRINT
Section A: Enrollee Information (all fields are required)

Employer Name
SMITH COUNTY SCHOOL DISTRICT

Social Security Number	First Name	MI	Last Name

Home Address	City	State	ZIP

Primary Telephone Number	Secondary Telephone Number	Personal Email Address

Marital Status	Gender	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement
☐ Single ☐ Married	☐ Male ☐ Female		

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____

If married, is your spouse a Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: _____

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

☐ **I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

☐ **I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan.** I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

Section C: Coverage

Enrollee Type:	Coverage Type:	Coverage Option: (Choose Only One)	Do you have Medicare? ☐ Yes ☐ No
☐ Employee - Legacy	☐ Enrollee Only	☐ Base	Medicare Number: _____
☐ Employee - Horizon	☐ Enrollee + Spouse	☐ Choice	☐ "A" Effective Date: _____
☐ Retiree	☐ Enrollee + Child	☐ Select	☐ "B" Effective Date: _____
☐ COBRA	☐ Enrollee + Children		Reason for Entitlement:
☐ Surviving Spouse	☐ Enrollee + Spouse & Child(ren)		☐ Age ☐ ESRD ☐ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA	☐ Active, ☐ Retiree or ☐ COBRA
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No
If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason

Section F: Change Information

☐ **Add Enrollee:** ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce
☐ Other: _____ Requested Effective Date: _____

☐ **Add Dependent(s):** ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: _____
(List all dependents in Section E.) Qualifying Event/ Effective Date: _____

☐ **Change Coverage:** ☐ Base Coverage ☐ Choice Coverage ☐ Select Coverage

Drop Dependent(s): ☐ Divorce ☐ Deceased ☐ Other: _____
Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date

Other Changes (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: **GROUP NUMBER:** _____
New Legacy Employee, Requested Effective Date: _____
New Horizon Employee, Requested Effective Date: _____
Retiree, Requested Effective Date: _____
COBRA, Requested Effective Date: _____
Surviving Spouse, Requested Effective Date: _____
Change(s), Requested Effective Date: _____

ENTERED BY: _____
DATE: _____

VERIFIED BY: _____
DATE: _____

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
MONTHLY PREMIUM RATES
Effective January 1, 2023

Legacy - Initially hired before 1/1/2006

Horizon - Initially hired on or after 1/1/2006

	LEGACY EMPLOYEES				HORIZON EMPLOYEES			
	CHOICE/BASE		SELECT		CHOICE/BASE		SELECT	
ACTIVE EMPLOYEE	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION	TOTAL PREMIUM	EMPLOYEE PORTION
Employee*	$437	$0	$457	$20	$437	$0	$483	$46
Employee + Spouse	$915	$478	$1,001	$564	$915	$478	$1,027	$590
Employee + Spouse & Child(ren)	$1,165	$728	$1,251	$814	$1,165	$728	$1,277	$840
Employee + Child	$561	$124	$648	$211	$561	$124	$674	$237
Employee + Children	$754	$317	$840	$403	$754	$317	$866	$429

***The State pays 100% of the employee's premium for Base Coverage. Active employees enrolling in Select Coverage must pay a portion of the employee premium.**

	LEGACY RETIREES		HORIZON RETIREES	
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE	CHOICE/BASE	SELECT	CHOICE/BASE	SELECT
Retiree	$502	$525	$802	$830
Retiree + Spouse (Non-Medicare)	$1,052	$1,151	$1,608	$1,712
Retiree + Spouse & Child(ren) (Non-Medicare)	$1,339	$1,438	$1,797	$1,902
Retiree + Child	$645	$716	$945	$1,021
Retiree + Children	$866	$908	$1,166	$1,213
Retiree + Spouse (Medicare)	N/A	$738	N/A	$1,043
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$929	N/A	$1,234
RETIRED EMPLOYEE - MEDICARE ELIGIBLE	**CHOICE/BASE**	**SELECT**	**CHOICE/BASE**	**SELECT**
Retiree	N/A	$213	N/A	$213
Retiree + Spouse (Non-Medicare)	N/A	$839	N/A	$1,095
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	$1,126	N/A	$1,285
Retiree + Child	N/A	$404	N/A	$404
Retiree + Children	N/A	$596	N/A	$596
Retiree + Spouse (Medicare)	N/A	$426	N/A	$426
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	$617	N/A	$617

	LEGACY		HORIZON	
COBRA	CHOICE/BASE	SELECT	CHOICE/BASE	SELECT
Participant	$445	$466	$445	$492
Participant + Spouse	$933	$1,021	$933	$1,047
Participant + Spouse & Child(ren)	$1,188	$1,276	$1,188	$1,302
Participant + Child	$572	$660	$572	$687
Participant + Children	$769	$856	$769	$883
COBRA DISABILITY EXTENSION	**CHOICE/BASE**	**SELECT**	**CHOICE/BASE**	**SELECT**
Participant	$655	$685	$655	$724
Participant + Spouse	$1,372	$1,501	$1,372	$1,540
Participant + Spouse & Child(ren)	$1,747	$1,876	$1,747	$1,915
Participant + Child	$841	$972	$841	$1,011
Participant + Children	$1,131	$1,260	$1,131	$1,299

OFFICE OF INSURANCE
QUICK REFERENCE GUIDE

Important Vendor Addresses and Telephone Numbers

Medical Claims Administration	**Blue Cross & Blue Shield of Mississippi (BCBSMS)** 3545 Lakeland Drive Flowood, MS 39232 800-709-7881
Health and Wellness Program Disease Management	**ActiveHealth Management, Inc. (ActiveHealth)** 4582 Ulster Street Parkway, Suite 900 Denver, CO 80327 866-939-4721
Medical Case Management Utilization Review	**Keystone Peer Review Organization (Kepro)** 2810 N Parham Road, Suite 305 Henrico, VA 23294 888-801-1910
Telehealth provider visits	**UMMC Telehealth** 2500 North State Street, Jackson, MS 39216 601-984-1000
Pharmacy Benefit Management	**CVS Caremark** P.O. Box 6590 Lee's Summit, MO 64064-6590 888-996-0050 www.caremark.com
Pharmacy Mail Order Program	**CVS Caremark** P.O. Box 94467 Palatine, IL 60094-4467 888-996-0050
Specialty Pharmacy Network	**CVS Specialty** 800-237-2767 www.cvsspecialty.com
Life Insurance Company	**Minnesota Life Insurance Company, an affiliate of Securian Financial Group** 400 Robert Street North St. Paul, MN 55101-2098 877-348-9217
Plan Sponsor	**State and School Employees Health Insurance Management Board** **c/o Department of Finance and Administration** **Office of Insurance** P.O. Box 24208 Jackson, MS 39225-4208 601-359-3411 866-586-2781

Vendor websites can be accessed through: http://www.dfa.ms.gov/insurance

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://KnowYourBenefits.dfa.ms.gov or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can also view the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network and Out-of-network: **$1,800**/individual; **$3,000**/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Preventive prescription drugs: **$75**/individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: **$6,500**/individual; **$13,000**/family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	20% coinsurance	40% coinsurance	Online provider visit: $10 (Subject to deductible)
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: $12 copay Mail order: $24 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	$75 individual preventive prescription drug deductible (for certain preventive medications) if the Base Coverage deductible has not been met. Mail Order (2X Copay) quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment. Certain prescriptions require prior approval.
	Non-Preferred Generic drugs	Retail: $30 copay Mail order: $60 copay		
	Preferred brand drugs	Retail: $45 copay Mail order: $90 copay		
	Non-preferred brand drugs	Retail: $100 copay Mail order: $200 copay		
	Specialty drugs	Retail: $100 copay	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease) • Dental care (Adult)	• Dental care (Children) • Hearing aids • Infertility treatment • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (prior approval required) • Chiropractic services (limited to 30 visits/individual/year)	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877-314-3843 or healthhelpms@mhap.org.

Does this **plan** provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this **plan** meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	**$1,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,000**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care provider office visits (*including chronic condition education*)
Diagnostic test (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$144
Coinsurance	$1091.20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,035.20**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	**$1,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*X-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$50
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.dfa.ms.gov/insurance or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can also view the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network and Out-of-network:**$3,300** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Preventive prescription drugs: **$75**/individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: **$13,000** family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions and Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	20% coinsurance	40% coinsurance	Online provider visit: $10 (Subject to deductible)
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: $12 copay Mail order: $24 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	$75 individual preventive prescription drug deductible (for certain preventive medications) if the Base Coverage deductible has not been met. Mail Order (2X Copay) quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment. Certain prescriptions require prior approval.
	Non-Preferred Generic drugs	Retail: $30 copay Mail order: $60 copay		
	Preferred brand drugs	Retail: $45 copay Mail order: $90 copay		
	Non-preferred brand drugs	Retail: $100 copay Mail order: $200 copay		
	Specialty drugs	Retail: $100 copay	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease) • Dental care (Adult)	• Dental care (Children) • Hearing aids • Infertility treatment • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (prior approval required) • Chiropractic services (limited to 30 visits/individual/year)	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877- 314-3843 or healthhelpms@mhap.org.

Does this **plan** provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this **plan** meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$3,300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,200**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care provider office visits *(including chronic condition education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$144
Coinsurance	$820
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,264**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	$3,300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://KnowYourBenefits.dfa.ms.gov or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can also view the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500**/individual; **$3,000**/family. Out-of-network: **$2,300**/individual; **$4,600**/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and primary care network provider office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Prescription drugs: **$75**/individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: **$6,500**/individual; **$13,000**/family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Go here for a list of network providers or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions and Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit. Deductible does not apply.	40% coinsurance	Online provider visit: $10 copayment
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work) Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: $12 copay Mail order: $24 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	$75 individual prescription drug deductible Mail Order (2X copay) Quantity: 60-90-day supply. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate or unavailable). If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment. Certain prescriptions require prior approval
	Non-Preferred Generic drugs	Retail: $30 copay Mail order: $60		
	Preferred brand drugs	Retail: $45 copay Mail order: $90 copay		
	Non-preferred brand drugs	Retail: $100 copay Mail order: $200 copay		
	Specialty drugs	Retail: $100 copay	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease) • Dental care (Adult)	• Dental care (Children) • Hearing aids • Infertility treatment • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (prior approval required) • Chiropractic services (limited to 30 visits/individual/year)	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877-314-3843 or healthhelpms@mhap.org.

Does this **plan** provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this **plan** meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles (Medical and Rx)	$1,500
Copayments	$0
Coinsurance	$2,240
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,740**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care provider office visits *(including chronic condition education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Medical and Rx)	$75
Copayments	$194
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$469**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$50
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

ActiveResources
Employee Account

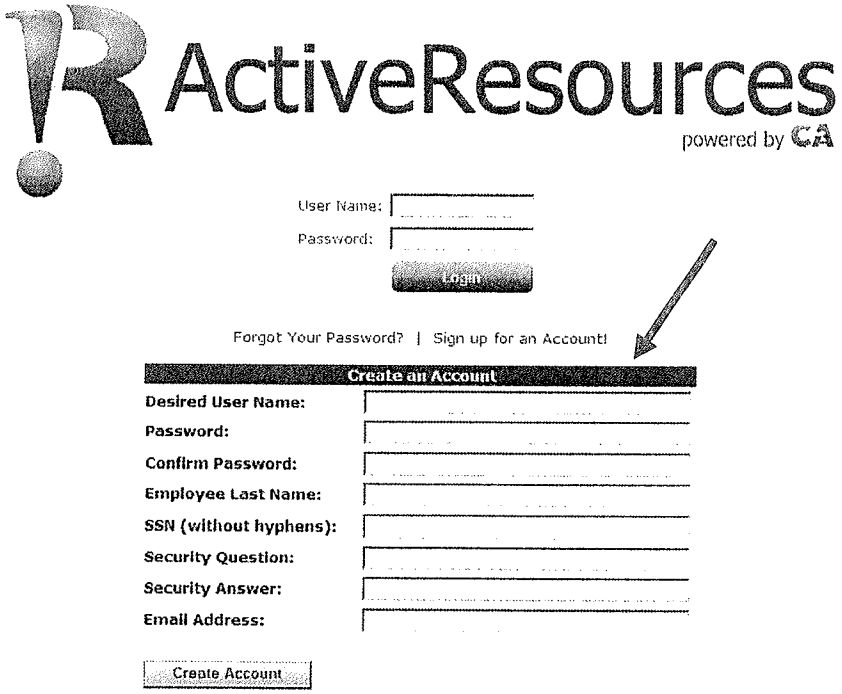
Create an Employee Account

All district employees will need to create an account on your initial visit to the ActiveResources site. To do this you will need to click on the **Sign up for an Account** option.

Clicking this option will expand the page where you will create an account.

ActiveResources
Employee Account

Expanded page



All fields must be completed in order for an account to be created.
Desired User Name: This can be anything that you want to use. It may be all alpha characters or an alphanumeric combination and there is no set length required.

Password: The password that you create must follow guidelines that are setup in Marathon. Parameters are the password length and whether or not non-alphabetic characters are required. You will receive notification if your password does not meet these criteria and you will be given an opportunity to try again.

Confirm Password: You will need to confirm your password by entering it again.

Employee Last Name: The last name entered **must** match your last name as it exists in your Marathon Payroll Employee folder.

SSN: The social security number entered **must** match your social security number maintained in your Marathon Payroll Employee folder. The employee's last name **and** social security number establishes the link between ActiveResources and Marathon.

Security Question: This should be something that is meaningful to you.

Security Answer: This is the answer to your security question.

Email Address: This should be the email address that you want any correspondence from ActiveResources to be sent to.

Once all of the information has been entered click on the **Create Account** button.

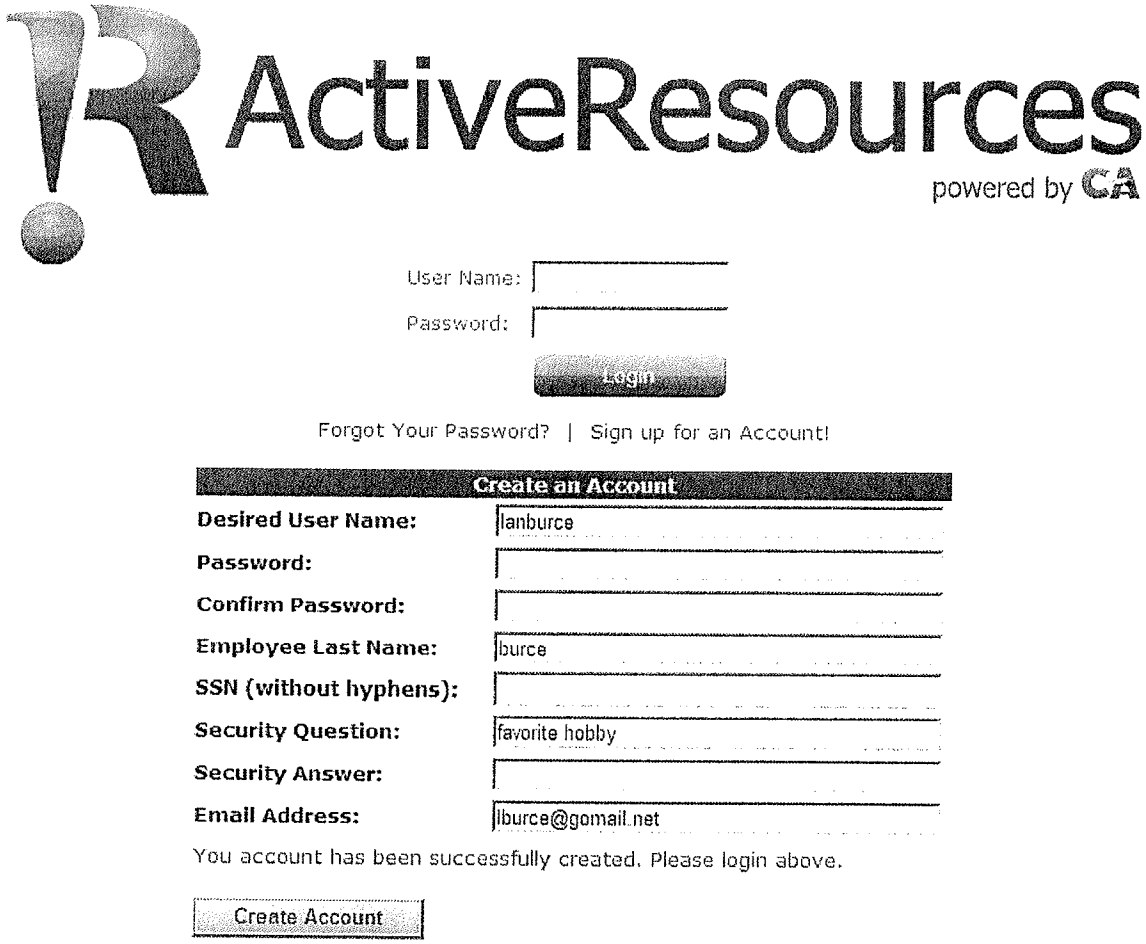
ActiveResources
Employee Account

Shown below is an example of an account **before** clicking the Create Account button.

The password, social security number and security answer are encrypted.

ActiveResources
Employee Account

Shown below is an example of an account **after** clicking the Create Account button.



Because the password, social security number and security answer are encrypted they are removed from the page.

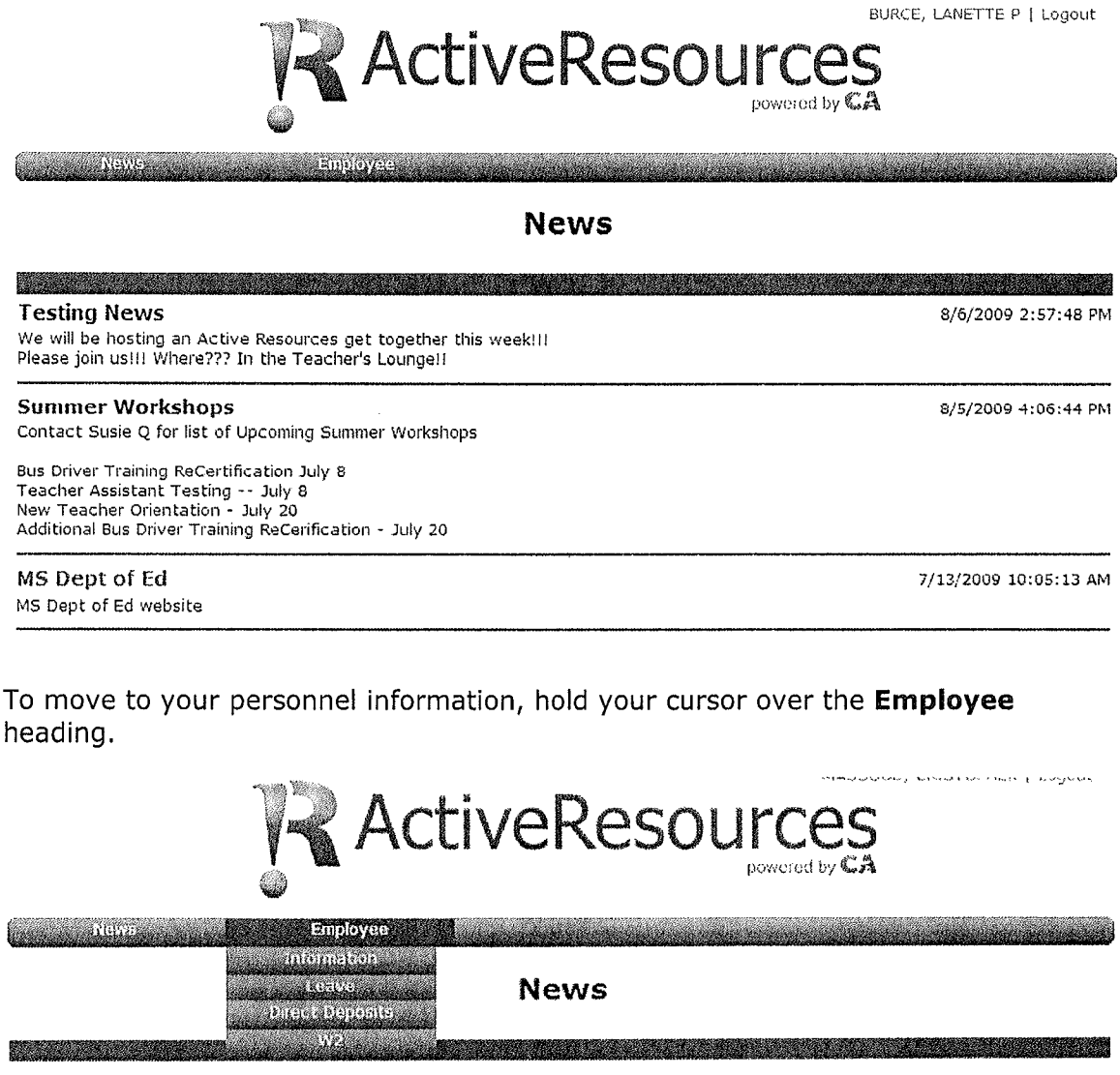
You will receive a visual confirmation that the account was created. You may now log in to ActiveResources by entering your user name and password and clicking on the **Login** button.

ActiveResources
Employee Account

Successful Login

Upon a successful login you will be on the **News** page. The News page will contain any news item that the District Office has created.

Note that in the example below, the news heading MS Dept of Ed is a link to another website.



To move to your personnel information, hold your cursor over the **Employee** heading.

You have four options to choose from: Information, Leave, Direct Deposits and W2

ActiveResources
Employee Account

Employee Information

The **My Information** page contains your personnel information that is **On File** in Marathon. Clicking on the **Request Change** label will direct you to another page where select pieces of information may be changed.

My Information

Basic Information

→ On File | Request Change ←

First:	LANETTE	**Address1:**	805 DEMO LANE
Middle:		**Address2:**	
Last:	BURCE	**City:**	RIDGELAND
Suffix:		**State:**	MS
Race:	BLACK	**Zip:**	39157 0000
Sex:	FEMALE	**Day Phone:**	601 5551915
DOB:	12/07/1959	**Night Phone:**	601 5555915
Hire Date:	08/01/1983		

Tax Setup

Federal Marital Status:	Married
Number of Exemptions:	1
State Marital Status:	Married - Spouse is Employed
State Exemption Amount:	7500.00
EIC Status:	No

Tax Withholding Information

Description	Pre-Tax	Post-Tax	Amount
FEDERAL WITHHOLDING		√	$0.00
FICA		√	$0.00
STATE WITHHOLDING		√	$0.00
RETIREMENT	√		$0.00
MEDICARE		√	$0.00
CE DEPT OF FINANCE-CAFETERIA	√		$563.00
LE STATE LIFE INS EMPLOYEE		√	$10.08
RJ AMERICAN UNITED OPTIONAL		√	$3.60

ActiveResources
Employee Account

Request Change

You may request a change on any item that is in an editable box. Click in the box and replace the information.

My Information

Basic Information

On File | Request Change

First:	LANETTE	**Address1:**	805 DEMO LANE
Middle:		**Address2:**	
Last:	BURCE	**City:**	RIDGELAND
Suffix:		**State:**	MS
Race:	BLACK	**Zip:**	39157 0000
Sex:	FEMALE	**Day Phone:**	601 5551915
DOB:	12/07/1959	**Night Phone:**	601 5555915
Hire Date:	08/01/1983		

Submit Request

Tax Setup

Federal Marital Status:	Married
Number of Exemptions:	1
State Marital Status:	Married - Spouse is Employed
State Exemption Amount:	7500.00
EIC Status:	No

Tax Withholding Information

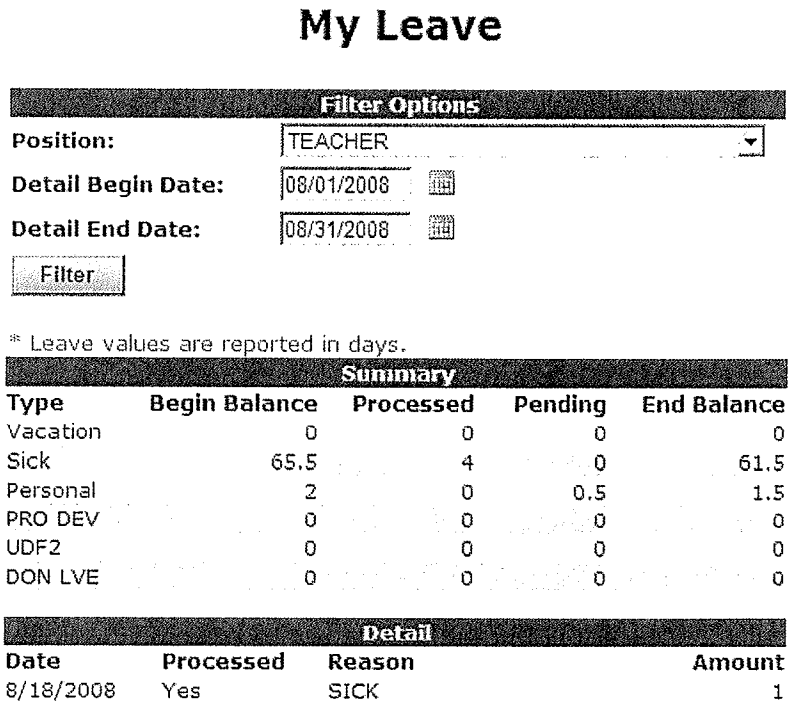
Description	Pre-Tax	Post-Tax	Amount
FEDERAL WITHHOLDING		√	$0.00
FICA		√	$0.00
STATE WITHHOLDING		√	$0.00
RETIREMENT	√		$0.00
MEDICARE		√	$0.00

Click the **Submit Request** button once you have made your changes. Submitting a change request will send an email to a designated Marathon Administrator. You will receive a confirmation email once your changes have been approved.

Should you check your information again before the change has been approved, you will see that the **On File** information remains the same but the **Request Change** page will highlight in blue any pending request changes. You may make an additional request, which will be processed as a separate request change.

Employee Leave

The **My Leave** page provides you with your leave balances. If you have multiple jobs with leave, you may pick the position from the Position list. The leave balances will be displayed accordingly.



My Leave

Filter Options

Position: TEACHER

Detail Begin Date: 08/01/2008

Detail End Date: 08/31/2008

Filter

* Leave values are reported in days.

Summary

Type	Begin Balance	Processed	Pending	End Balance
Vacation	0	0	0	0
Sick	65.5	4	0	61.5
Personal	2	0	0.5	1.5
PRO DEV	0	0	0	0
UDF2	0	0	0	0
DON LVE	0	0	0	0

Detail

Date	Processed	Reason	Amount
8/18/2008	Yes	SICK	1

The information contained on this page is as follows:
Type: The type identifies the different types of leave available in your district. You may not be eligible for all leave types based on your position.

Begin Balance: The Begin Balance is the number of days or hours that you have at the beginning of the current fiscal year.

Processed: Processed leave records are those that are associated with prior payrolls.

Pending: Pending leave records are those that will be a part of an upcoming payroll.

End Balance: The ending balance is the beginning balance minus the processed and pending leave records.

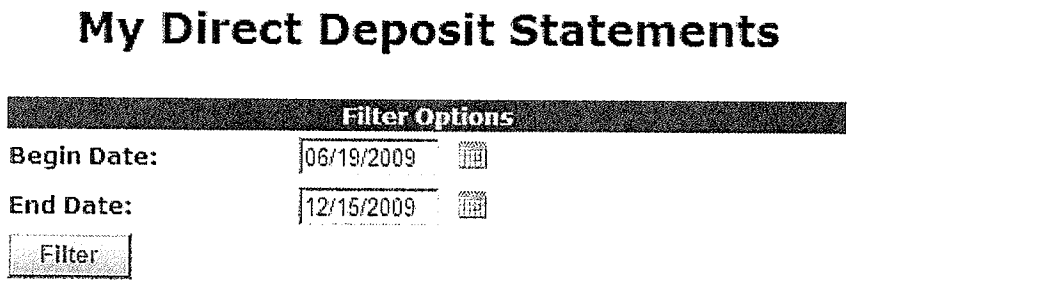
If you would like to see the detailed information for a specific timeframe, you may enter a beginning and ending date range and click the **Filter** button. The Detail section will show you the date that the leave was taken, whether the record has been processed or is pending, the leave reason and the amount of leave taken.

ActiveResources
Employee Account

Employee Direct Deposits

You may be able to receive your direct deposit statements electronically through Active Resources under the following conditions:

(a) You must participate in your district's direct deposit system
(b) Your district allows you to receive your statement electronically

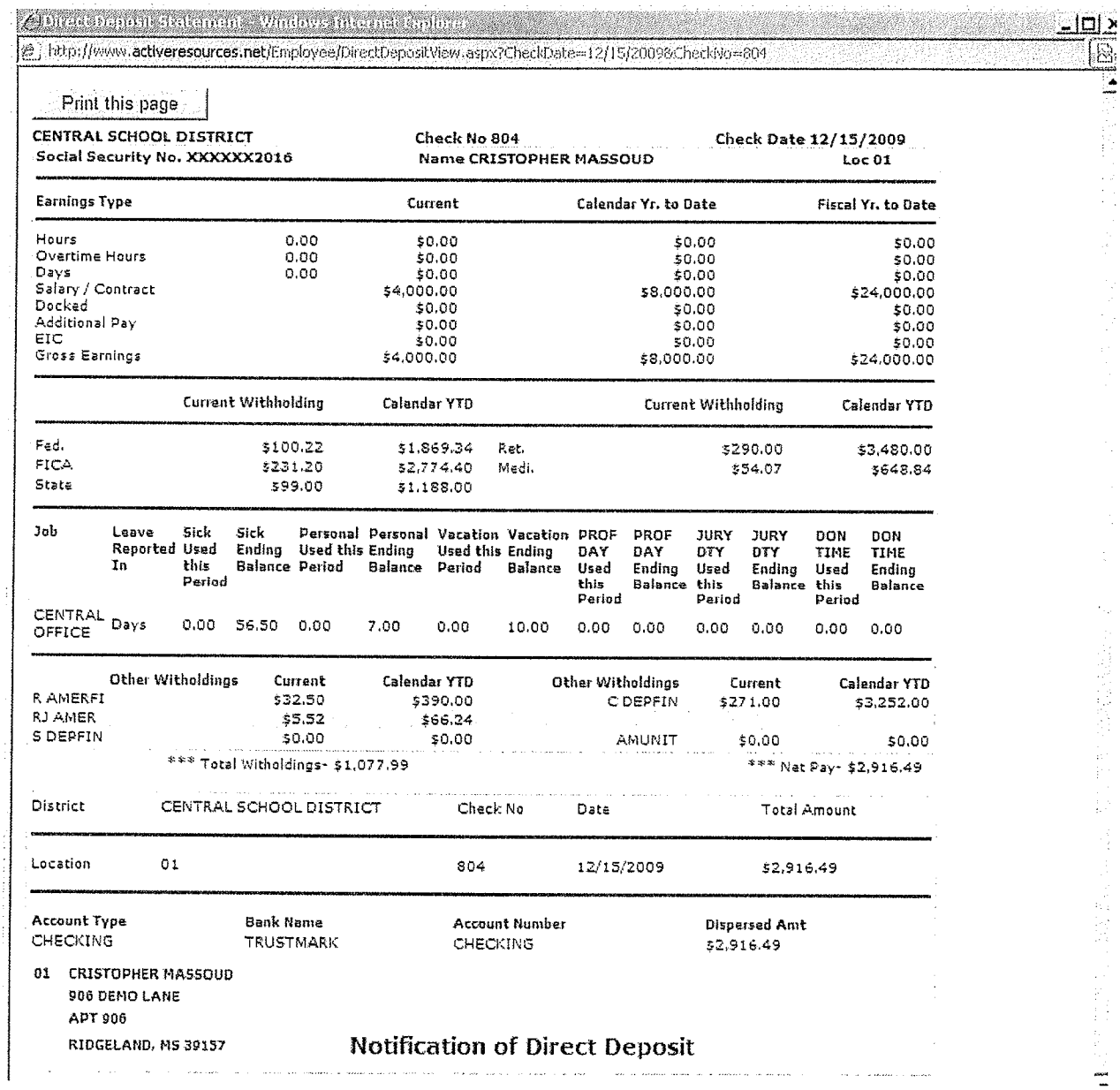


Filter Options – There will always be a default date range in the Begin and End Date fields. If you change either date, you will need to click the **Filter** button to refresh the list of available statements.

Direct Deposit Statement List – All available statements that fall within the date range will be displayed in descending date order. To view a statement, click on the desired date.

ActiveResources
Employee Account

Sample Direct Deposit Statement



Direct Deposit Statement - Windows Internet Explorer

http://www.activeresources.net/Employee/DirectDepositView.aspx?CheckDate=12/15/2009&CheckNo=804

Print this page

CENTRAL SCHOOL DISTRICT — **Check No 804** — **Check Date 12/15/2009**
Social Security No. XXXXXX2016 — **Name CRISTOPHER MASSOUD** — **Loc 01**

Earnings Type		Current	Calendar Yr. to Date	Fiscal Yr. to Date
Hours	0.00	$0.00	$0.00	$0.00
Overtime Hours	0.00	$0.00	$0.00	$0.00
Days	0.00	$0.00	$0.00	$0.00
Salary / Contract		$4,000.00	$8,000.00	$24,000.00
Docked		$0.00	$0.00	$0.00
Additional Pay		$0.00	$0.00	$0.00
EIC		$0.00	$0.00	$0.00
Gross Earnings		$4,000.00	$8,000.00	$24,000.00

	Current Withholding	Calendar YTD		Current Withholding	Calendar YTD
Fed.	$100.22	$1,869.34	Ret.	$290.00	$3,480.00
FICA	$231.20	$2,774.40	Medi.	$54.07	$648.84
State	$99.00	$1,188.00			

Job	Leave Reported In	Sick Used this Period	Sick Ending Balance	Personal Used this Period	Personal Ending Balance	Vacation Used this Period	Vacation Ending Balance	PROF DAY Used this Period	PROF DAY Ending Balance	JURY DTY Used this Period	JURY DTY Ending Balance	DON TIME Used this Period	DON TIME Ending Balance
CENTRAL OFFICE	Days	0.00	56.50	0.00	7.00	0.00	10.00	0.00	0.00	0.00	0.00	0.00	0.00

Other Witholdings	Current	Calendar YTD	Other Witholdings	Current	Calendar YTD
R AMERFI	$32.50	$390.00	C DEPFIN	$271.00	$3,252.00
RJ AMER	$5.52	$66.24			
S DEPFIN	$0.00	$0.00	AMUNIT	$0.00	$0.00

*** Total Witholdings- $1,077.99 — *** Net Pay- $2,916.49

District	CENTRAL SCHOOL DISTRICT	Check No	Date	Total Amount
Location	01	804	12/15/2009	$2,916.49

Account Type	Bank Name	Account Number	Dispersed Amt
CHECKING	TRUSTMARK	CHECKING	$2,916.49

01 CRISTOPHER MASSOUD
906 DEMO LANE
APT 906
RIDGELAND, MS 39157

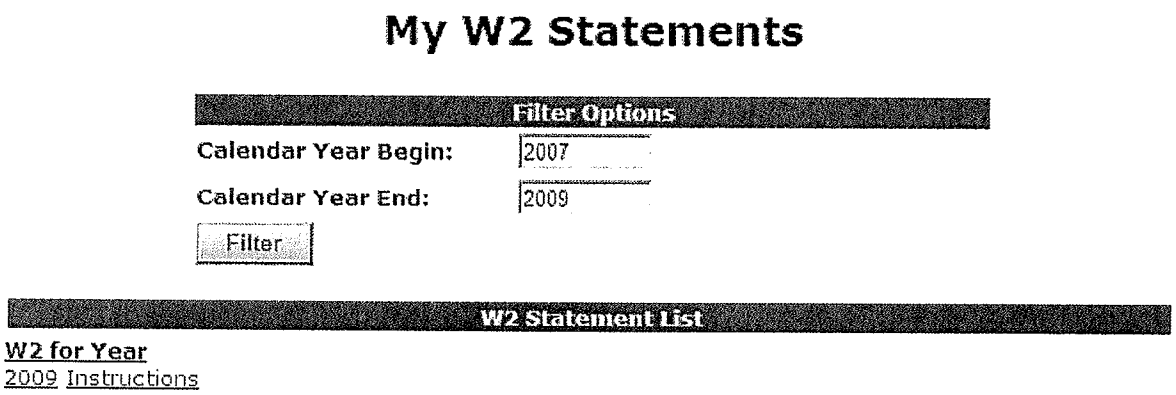
Notification of Direct Deposit

You may print the statement or close out by clicking the **X** button in the upper right hand corner.

ActiveResources
Employee Account

Employee W2 Form

You may be able to view your W2 Form through Active Resources. This option will only be available to those districts that elect to use this electronic format.

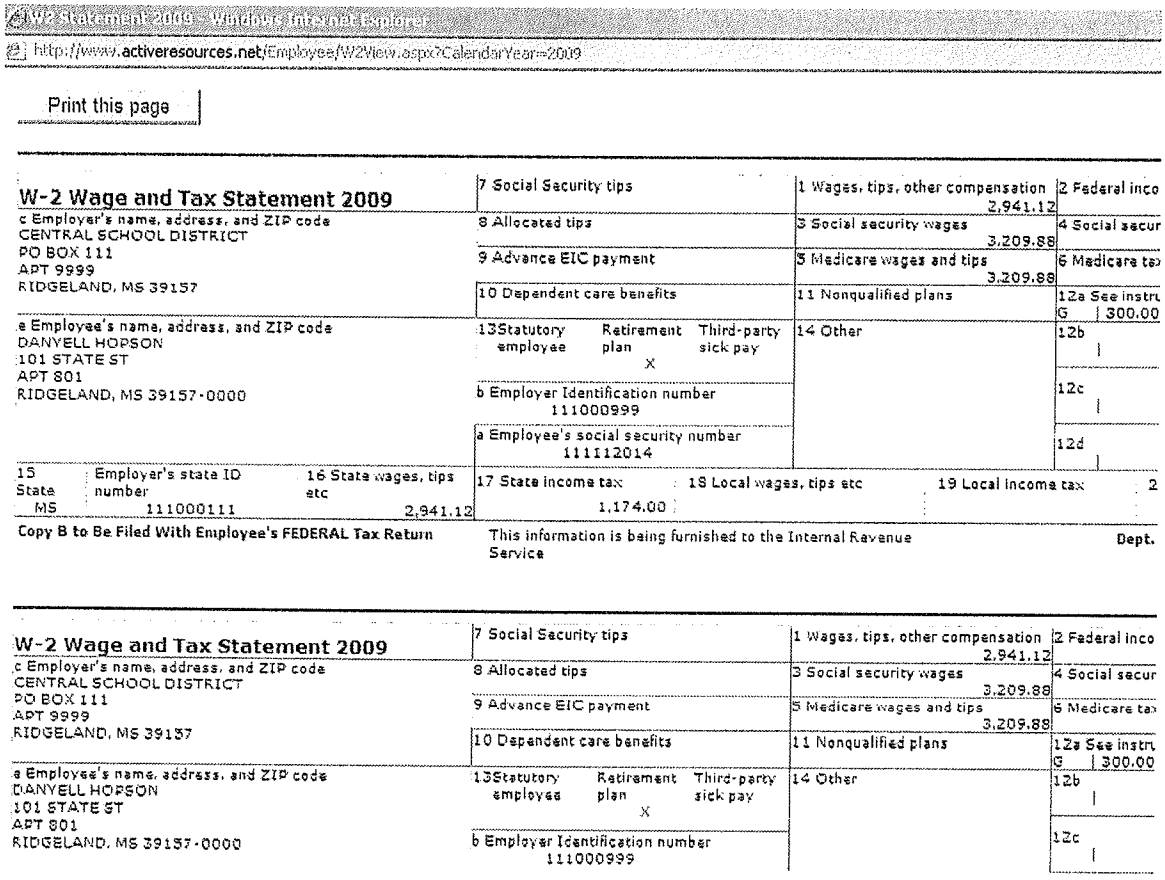


Filter Options – Only calendar year 2009 will be available this year. Each subsequent calendar year will be added to this list.

W2 List – To view the W2 Form, click on the calendar year, e.g. **2009**. You may also view an instruction page. The instructions are those that are printed on the back of the official W2 Form. To view this page, click on the label "**Instructions**".

ActiveResources
Employee Account

Sample W-2 Form



W2 Statement 2009 - Windows Internet Explorer

http://www.activeresources.net/Employee/W2View.aspx?CalendarYear=2009

Print this page

W-2 Wage and Tax Statement 2009

c Employer's name, address, and ZIP code
CENTRAL SCHOOL DISTRICT
PO BOX 111
APT 9999
RIDGELAND, MS 39157

e Employee's name, address, and ZIP code
DANYELL HOPSON
101 STATE ST
APT 801
RIDGELAND, MS 39157-0000

15 State	Employer's state ID number	16 State wages, tips etc	17 State income tax	18 Local wages, tips etc	19 Local income tax	2
MS	111000111	2,941.12	1,174.00			

7 Social Security tips		1 Wages, tips, other compensation 2,941.12	2 Federal inco
8 Allocated tips		3 Social security wages 3,209.88	4 Social secur
9 Advance EIC payment		5 Medicare wages and tips 3,209.88	6 Medicare tax
10 Dependent care benefits		11 Nonqualified plans	12a See instr G 300.00
13 Statutory employee	Retirement plan X	Third-party sick pay	14 Other	12b
b Employer Identification number 111000999				12c
a Employee's social security number 111112014				12d

Copy B to Be Filed With Employee's FEDERAL Tax Return — This information is being furnished to the Internal Revenue Service — Dept.

W-2 Wage and Tax Statement 2009

c Employer's name, address, and ZIP code
CENTRAL SCHOOL DISTRICT
PO BOX 111
APT 9999
RIDGELAND, MS 39157

e Employee's name, address, and ZIP code
DANYELL HOPSON
101 STATE ST
APT 801
RIDGELAND, MS 39157-0000

7 Social Security tips		1 Wages, tips, other compensation 2,941.12	2 Federal inco
8 Allocated tips		3 Social security wages 3,209.88	4 Social secur
9 Advance EIC payment		5 Medicare wages and tips 3,209.88	6 Medicare tax
10 Dependent care benefits		11 Nonqualified plans	12a See instr G 300.00
13 Statutory employee	Retirement plan X	Third-party sick pay	14 Other	12b
b Employer Identification number 111000999				12c

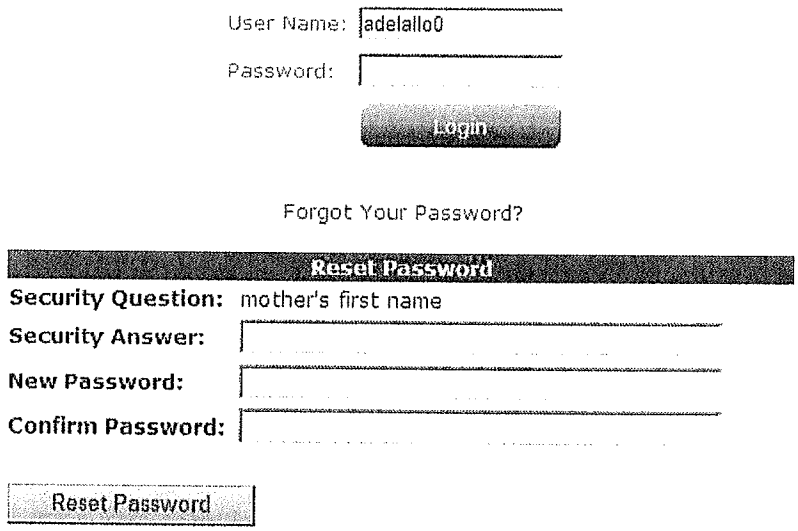
This form contains three sections: Copy B to be filed with your Federal Tax Return, Copy C for your records and Copy 2 to be filed with your State Tax Return.

You may print the page which has all three sections or close out by clicking the **X** button in the upper right hand corner.

ActiveResources
Employee Account

General Information

Should you forget your password you may use the "Forgot Your Password" option. You must first enter your User Name and then click on the Forgot Your Password link. This will bring up your security question, which must be answered correctly, along with the ability to create a new password.



Once the information has been entered, click the Reset Password button. You will receive confirmation that the password has been reset. You may now enter the new password and log into ActiveResources.

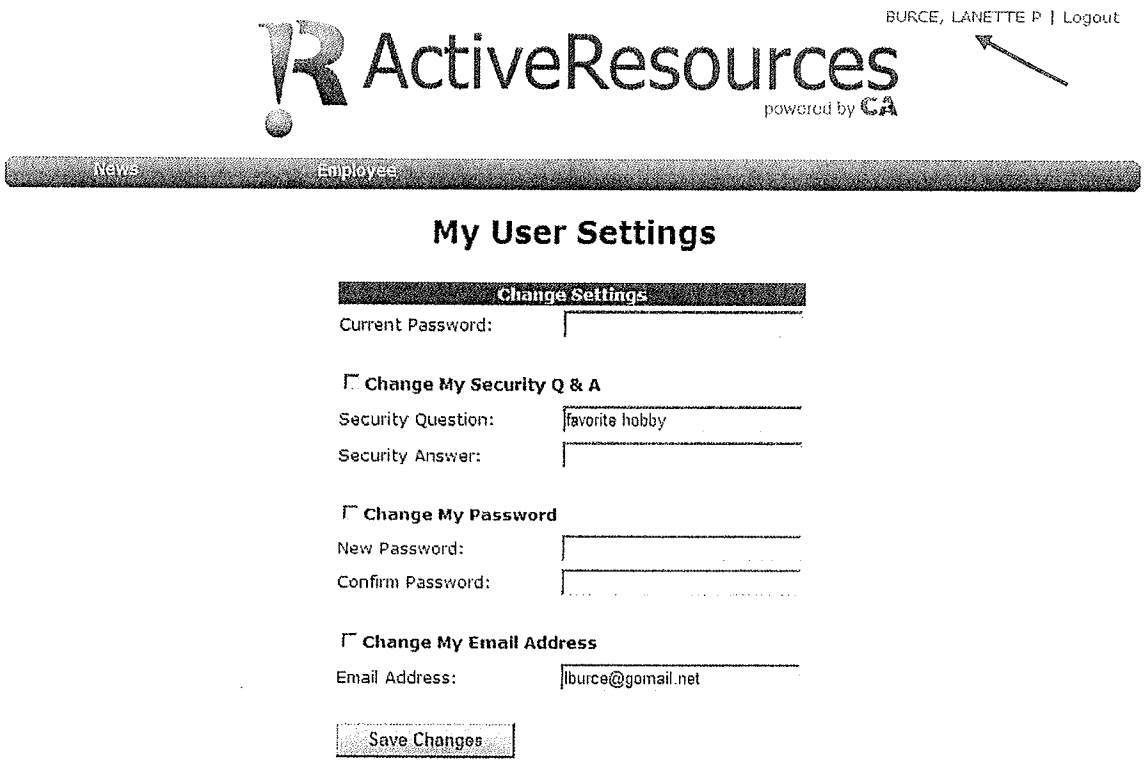
You will need to contact the Marathon Administrator in your district if you forget your User Name.

You are allowed a set number of login attempts, which is set by the Marathon Administrator, so it is very important to remember your User Name and Password. You will be locked out of ActiveResources if your failed login attempts exceed the allowance. The Marathon Administrator will receive an email informing them that you are now locked out of ActiveResources. You will receive a confirmation email once your account has been unlocked.

ActiveResources
Employee Account

My User Settings

Clicking on your name located in the upper right hand corner will bring up a My User Settings page.



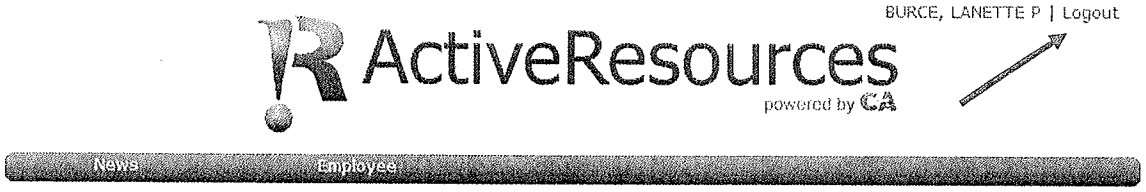
You **must** enter your current password before you can save any changes.

To make a change, click in the small box that identifies the section that you want to change.

Enter in the new information and click the **Save Changes** button.

ActiveResources
Employee Account

Be sure to log out when you are through reviewing your information.



To log out click on the **Logout** button.